

A CRITIQUE OF PSYCHOTHERAPY IN ARTERIAL HYPERTENSION*

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I^N considering the complicated subject of arterial hypertension it is appropriate at this time to review the experiences with psychotherapy. Both in this approach and in others there is admittedly a great deal that we do not yet know. Professor George Santayana used to talk about defining the limits of our ignorance. What are these limits?

We do not know, for example, whether the process is a reversible one, whether the impulses which give rise to arteriolar constriction are humoral or neural in origin, or both. In spite of the brilliant researches of Goldblatt¹ and others, we do not know what part the kidneys and the renal circulation play in bringing it about. Indeed, it would be hard for us to define this disease further than to say that it represents a morbid state in which elevation of the systolic and diastolic blood pressures—either fluctuating or constant—occur in association with arteriolar vasoconstriction. We do not know why the life expectancy of some is unaffected while others succumb quickly to the malignant form.

Once we thought that hypertension was associated with a certain bodily habitus—that it was more prone to exist among the short and the squat and the red-faced. Those of you who have occasion to see patients suffering from this disturbance have found them to be lean and spare, tall and pale-faced as well. According to Page,² “an accurate correlation of body build, height and surface area with arterial pressure cannot be established”. Again citing Page as my authority, and contrary to generally accepted beliefs, there is no sufficiently documented testimony to support the view that heredity plays a vital part in the genesis of hypertension. He cautions against ascribing too great importance to heredity and suggests that this aspect of the problem needs reinvestigation on a more comprehensive basis.

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This then is part of the staked-out claim of our ignorance. To outline it is not to underestimate the importance of recent researches and their contribution to our understanding of the physiological mechanisms of this disorder.

That it has still another aspect is now rather generally accepted. In this terrain our ignorance is even wider and more varied. It would be a challenge, indeed, to plumb its depths and to chart its perimeter. I am speaking now, of course, of the psychological aspects of arterial hypertension which some have attempted to explore: Alexander,³ Menninger,⁴ Moschowitz,⁵ Rennie,⁶ Saul⁷ and Weiss⁸ among others. In collaboration with Nathan Ackerman,⁹ I have myself put in four years at hard labor breaking ground. I cannot say that we struck gold, but I hope at least that we uncovered some facts. These are to be published in a much over-due monograph of which the page proof has finally come through. The work was supported by a grant from the Josiah Macy, Jr. Foundation and was done in coöperation with Drs. Cohn, Schroeder and Steele of the Hospital of the Rockefeller Institute. The investigation was based on the clinical and psychiatric study of 24 patients suffering from arterial hypertension.

I should like to say here in parenthesis that the description of the personalities of these patients which I shall presently offer and which derives from our own work and, in part, from that of others does not, in all probability, apply uniquely or exclusively to the hypertensive state, though none of our patients differed widely from it. I have, myself, yet to be convinced that characterological studies made by those interested in psychosomatic medicine have any specific etiological significance. Not beauty alone but artefacts as well may dwell in the eye of the beholder.

The facts that appear from our own studies and from others' are these: Sufferers from arterial hypertension exhibit a disorder of personality which has been conveniently described by the term "neurotic." This disorder manifests itself in their inter-personal relationships, in their sexual adjustments and often in their occupational achievements. They are characteristically tense individuals given to states of anxiety and depression. Much of their emotional tension can be ascribed to inhibited, but not deeply repressed, aggressive impulses. It is often possible to trace the history of this neurotic development of character to early childhood when the common feature is an extreme degree of

insecurity, with a greatly unsatisfied dependent relationship to a threatening parent. Given this bad start the patient then falters through life—unable to relax, unable to enter into secure and satisfying relationships, always on the defensive, ready to fight but afraid to fight.

With this precarious adjustment the apple-cart of the patient's emotions is easily upset. The death of a parent, or partner, a motor accident, the illness of a child, business reverses—almost any event which jeopardizes his security—which is felt either directly or by implication as a threat to his life—increases to an intolerable degree the quantum of his anxiety and of his reactive depression. In our series of cases it was observed that the clinical discovery of elevated blood pressure frequently coincided with such a traumatic experience.

I do not wish to be understood as stating that this disturbance of character or its ultimate outcome is the cause of hypertension. It is, on the contrary, my suspicion that the psychological disorder and the physiological disorder each represents a different aspect of a more basic disturbance, the nature and cause of which is unknown—though its existence is often foreshadowed early in life.

What therapeutic implications are to be drawn from these observed facts and from this theoretical interpretation of them? The first is that psychotherapy cannot be directed at blood vessels. It can be directed at the emotions. Its aim is to treat the person, not the vaso-constrictor mechanism. This must be kept clearly in mind. What we can accomplish will depend—as in any other therapeutic procedure—not only upon our skill, but also upon the material with which we are forced to deal. It is not a plastic, easily workable one. These patients have usually extraordinarily rigid personalities. Their aggressions are fixed, they are not fluid or readily mobilizable. If they were, they themselves would have spontaneously found a more satisfactory and less destructive expression for them. Much of their anxiety is absorbed in their symptoms. It is not easily dislodged and when it is it may sweep over them and produce a state bordering on panic. The underlying depression is constantly being fed by the conviction that they are sufferers from a fell malady, that fate has dealt them a body blow. Each symptom winds up the main spring of their tension, increases their anxiety and undoubtedly reflects itself in their vascular apparatus. Deep psychotherapy in this illness is, therefore, no task for the bungler or the amateur. It is as dangerous, as delicate and as difficult as surgery.

Like the surgeon the psychotherapist must know something of the topographical anatomy of his patient. His aims are to restore a more normal functioning of the emotions. Persuasion and reassurance, though important tools, are seldom sufficient. They will not remove tough bands of connective tissue and they will seldom remove the strictures and inhibitions against which these patients live their unfulfilled lives.

Again like surgery, the choice of procedure will depend not upon pre-conceived doctrinaire generalizations but upon careful clinical observation. It is as absurd to say that every patient suffering from hypertension should undergo psychoanalysis as it is to say that every case of neoplastic disease should be operated upon. The decision is based first of all on the patient's ability to stand operation, secondly upon the nature of the lesion and its accessibility, and thirdly upon the prospects for a successful result. Surgeons no longer operate because there is nothing else to do, but rather for specific reasons empirically derived. In the domain of psychiatry and psychoanalysis the same critical standards are now happily being invoked.

The surgeons have, to be sure, a great advantage over us; not only is their handiwork more precise, but their results are referable to a statistic which it would be folly to assert that we possess. We have none.

Lacking a statistic we can at best proceed according to certain rational principles. I have stated what they are. The problem is that of treating a severe character neurosis in which anxiety, depression and suppressed aggression are the cardinal psychopathological features. The method of choice will vary from cheerful neglect (based on that much vaunted common sense which we are all supposed to possess in such good measure) to deep psychological exploration. The latter you will grant is a matter for the expert. What is to be hoped from it we cannot say. There is as yet no evidence that psychoanalysis or any other psychotherapeutic procedure can reverse the physiological process or change the destiny of this disease—be it benign or malignant. The problem is an open one. It needs further investigation. The ground has now been cleared for such an undertaking. It is probable that we can do more by way of prevention than cure.

There is evidence that a correlation exists between levels of pressure and emotional disturbance and that suitable psychotherapy can ameliorate some symptoms: such as headache, fatigue, palpitation, dizziness, shortness of breath and the fear which these engender.

We have observed this ourselves and so have others. Weiss¹⁰ has stated for example: "For some time now I have felt and taught that essential hypertension cannot be eradicated by any psychotherapeutic process but that almost every patient can be benefitted by psychotherapy". In a review⁸ of the records of 200 consecutive patients with symptoms of hypertension he selected 144 which "seemed to correspond to the clinical picture of so-called essential hypertension" (note the cautious conservatism of his words). Ninety-three of these lent themselves to satisfactory psychosomatic investigation and in only seven did he conclude that psychic factors bore no relationship either to the onset of hypertension or to the production of symptoms. Case I. of his series shows a quite remarkable coincidence between periods of elevated blood pressure and vaso-spastic retinitis with anxiety producing episodes and with what Weiss calls periods of "throttled aggression."

In Alexander's³ carefully studied psychoanalytic material he presents blood pressure readings of 161/110 when his patient was emotionally disturbed as compared with 142/98 when calm. Saul⁷ has made similar observations of fluctuations of blood pressure with mood and, more especially, with variations in the intensity of the so-called transference situation. It must be borne in mind that fluctuations may occur spontaneously without reference to known therapeutic effects.

The most striking, unique and dramatic case in the literature is a patient of Lewis B. Hill,¹¹ who recalled early in the course of psychoanalytic treatment a deeply suppressed childhood memory. This was brought up with intense effect. The patient exhibited an extraordinary degree of rage and guilt over a childhood experience in which his mother struck him with a pony whip. The recall and reliving of this traumatic episode was followed by a critical sustained and enduring fall of both systolic and diastolic pressures. Perhaps this single observation is a prototype of others to come. But, in honesty, it must be said that from a clinical and physiological point of view the case is insufficiently documented and the diagnosis remains open to question.

Leaving now out of consideration all efforts at deeper psychodynamic inquiry and turning to the every day handling of these patients, I believe that our new knowledge can be put to effective use. We are dealing with tender vessels. They need to be protected from emotional strain, especially from demands upon a self-reliance they do not possess. There is no good in telling them to "buck up" and "forget

it." They need the maximum of reassurance about the disease itself. They need very much to feel that some one person is watching over them and will take on his shoulders the burdens of their worries. They need to be encouraged to express their aggression, not by hurling dishes or epithets at their wives, but by directed work and play and by physical exercise, if this is compatible with their cardiac reserve. They need to be weaned away from an over-concern with the level of their blood pressure. The experienced doctor will vary his methods. With some he will be frank, with others he will be silent and to some he will have to dissemble. The manner in which this frightening fact is first presented to them is of the utmost significance. If the doctor shows his own alarm when the mercury column tops 220 it is likely to be communicated at once to his patients.

It is well to remember that almost all our therapy is in essence psychotherapy. Drugs and sedatives, rest and exercise, diet and baths all have psychotherapeutic implications; and this is just as true of surgery. The surgical amphitheatre has become the court of last resort in this illness. Perhaps in time we will learn on what findings nature bases her verdict—why some patients respond to sympathectomy with a reduction in blood pressure, a recession of retinitis and a merciful relief from headache, while others do not. I hope that it will not be thought too "tender-minded" of me if I suggest that the attitude which patients bring to the ordeal of operation may in some measure determine its effect upon them. For there are those who face it as they would doom and there are others who look upon it as a deliverance.

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